

Individual Practitioner Application for Privileging to Render Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT)

Complete this application and email it to networkmgt@cardinalinnovations.org or send by fax to 704-939-7513

*Please note that to eventually qualify for reimbursement for assessments at the higher rate for TF-CBT, the assessments should be completed consistent with the template Cardinal Innovations has adopted. Privileging approval, if granted, will be good through the end date of the clinician's active professional license. **Please also note that TF-CBT and PCIT privileging is not available to associate level clinicians.***

1. Clinician's name, professional license type and number:

Name _____

Professional License

(e.g. MD, LP, LCMHC, LCSW) _____ License No. _____

2. Clinician's Social Security number, National Provider Identification Number (NPI) and Taxonomy:

Social Security Number

NPI

Taxonomy

3. Are you currently associated or employed with an already contracted Cardinal Innovations Healthcare provider?

Yes | Proceed to Question 4

No | *Please also submit a credentialing registration form along with this TF-CBT application. The form can be found on our website, www.cardinalinnovations.org, under "Resources" and clicking on "Resource Library" and typing in LIP in the search box on the left side of the page.*

4. Name and address of Agency/Practice Clinician where clinician intends to render TF-CBT or PCIT Services:

Practice Name

Street

City

State

ZIP

Clinician Additional Practice Locations (If Necessary)

Practice Name

Street

City

State

ZIP

Is the above address(es) reflected in clinician's record at NCTracks? Yes No

If No | Please submit an MCR in NCTracks to affiliate the address(es) listed above in question 4.

(Make sure to print/save a copy and submit with this application if applicable.)

5. Please select which of the following option(s) apply to you:

TF-CBT

- On Roster for North Carolina Child Treatment Program (NC CTP)
- Must have fully completed training
 - Please attach training certificate/evidence of completion of the learning collaborative

- On Roster for Project Best at MUSC

Please list the county in which you are rostered: _____

- Must have fully completed Project Best at MUSC, including the learning collaborative
- Please Note: the 10 Hour online course is not considered sufficient for privileging
- Please attach training certificate/evidence of completion of the learning collaborative

- On Roster for National Therapist Certification Program for Trauma Focused Cognitive Behavioral Therapy (TFCBT.org)

- On Roster with the Program for Adolescent Traumatic Stress through MUSC (PATS)

Please list the state in which you are rostered: _____

- Trauma focused training that included supervision of cases and fidelity monitoring
- *Please include training certificates, summary describing the training, hours of training, supervision hours, credentials/background of the trainer, and other clinician information to demonstrate training consistent with best practices.*

PCIT

- Certification by PCIT International
- *Must have fully completed training*
 - *Please attach training certificate/evidence of completion of the learning collaborative*

6. TF-CBT/PCIT Supervision – Please describe and explain the ongoing supervision that will be received related to this treatment or attach a supervision agreement. This is required to receive the enhanced rates for any clinician that has been practicing the model for less than five years.

7. TF-CBT/PCIT Fidelity – Please describe and explain, or attach documentation, regarding what measurements will be in place to demonstrate on an ongoing basis that the treatment is being implemented with fidelity to the model.

The undersigned hereby affirms that the information set forth in this application is true and correct to the best of their knowledge, information and belief.

Signature of Practitioner

Date

Practitioner Email Address for Follow-Up and Decision Notifications